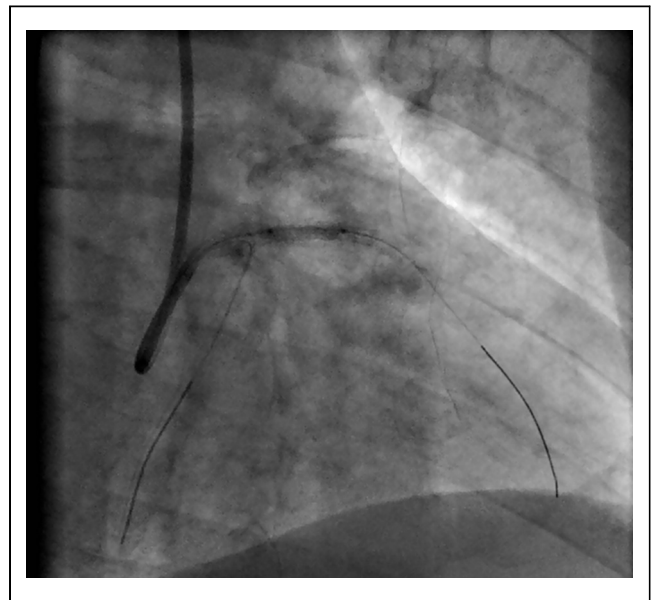
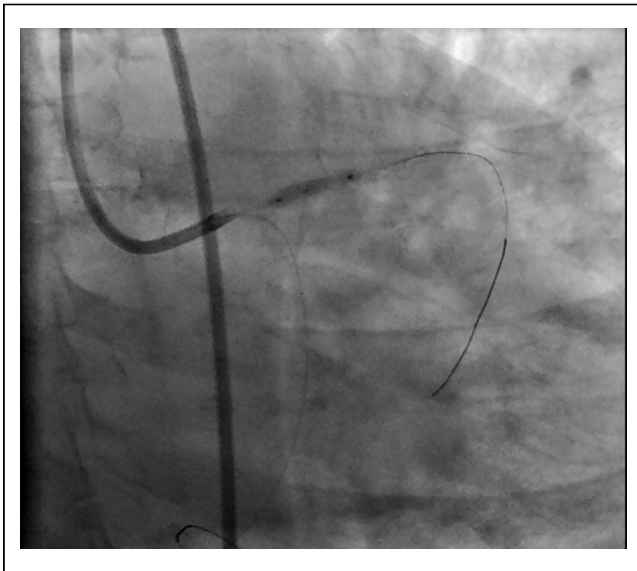


#### [INTERVENTIONAL MANAGEMENT]

**Procedural step.** Transfemoral access extra back up 3.5 guide, both the arteries were wired, predilatation done and distal left main was addressed by mini crush technique with final kissing balloon



**Case Summary.** This was dominant left sided circulation. The circumflex ostium was critically narrow 2 stent strategy was adopted which turn out to be good final end result.

#### TCTAP C-029

**Simultaneous Non-Culprit Vessel Intervention During Primary Angioplasty for ST Elevation Myocardial Infarction**

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#### [CLINICAL INFORMATION]

**Patient initials or identifier number.** CMGK

**Relevant clinical history and physical exam.** 54 yr old male, admitted with central chest pain and profuse sweating

Smoker, with Type 2 Diabetes, Dyslipidemia,

Pulse 100/min, sinus rhythm. BP 120/86

No evidence of heart failure

Provisional diagnosis of ACS - STEMI - Inferolateral wall

**Relevant test results prior to catheterization.** Troponin- I and CPK-MB elevated

ECG- Sinus rhythm, 100/mt, ST elevation in V5,V6, II, AVF, Q in II, aVF and poor R waves in V1 to V6

2D Echo: RWMA mid/distal lateral wall; LVEF -65%

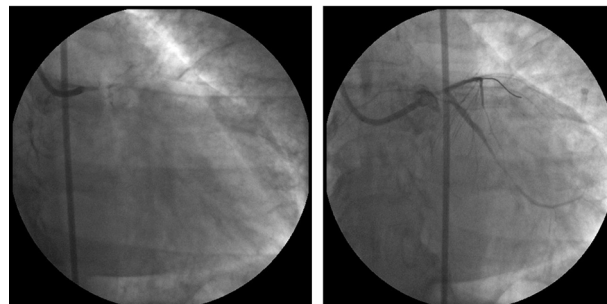
#### [INTERVENTIONAL MANAGEMENT]

**Procedural step.** 2 cases presented

Case 1- Culprit lesion in LCX; Primary angioplasty to LCX done. But thrombus containing lesions in the proximal LAD and proximal RCA visualized. Large area of myocardium under immediate jeopardy. Hence simultaneous angioplasty to the coexistent non-culprit but potentially culprit lesions in the LAD and RCA possibly justified in the same setting. Simultaneous thrombi in multiple coronaries during STEMI though rare, may occur and is associated with worse prognosis.

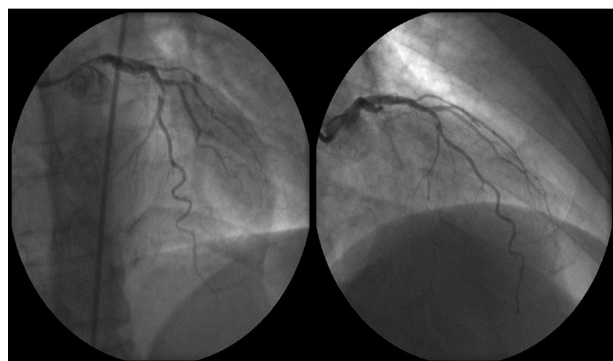
Case 2 - Culprit lesion is the total occlusion of distal LMCA. On wiring the LAD, flow is re-established and shows that the culprit lesion is from the LMCA to LAD. LCX ostium and proximal LCX is normal, but mid LCX shows a long segment critical narrowing of 80%. Because the primary strategy would be LMCA to LAD stenting, simultaneous angioplasty and stenting to the non-culprit mid LCX lesion is considered to avoid future recross with a long stent into the LCX across the struts of the LMCA stent.

Case 2: 73 year old with extensive anterolateral STEMI and totally occluded LMCA



Wire passed into the LAD and flow into LAD and LCX established  
Shows a critical long mid LCX lesion after which maybe difficult to access  
After PCI and stenting from the LMCA into the LAD  
Hence the rationale to intervene in LCX during index PCI For STEMI

Critical thrombus containing lesion in the LAD in patient with STEMI and totally occluded LCX



Case 1

**Case Summary.** Multi vessel disease and Non-culprit lesions in STEMI is a heterogeneous entity.

Treatment approach has to be individualized.

Current guidelines recommend single vessel (Infarct related artery) PCI as the default strategy in STEMI.

Acute multi -vessel PCI is justified only in patients with cardiogenic shock.

Role of multivessel PCI during the index primary angioplasty for STEMI is a gray zone.

Recent trials have questioned the wisdom of labeling as a Class III recommendation for multivessel PCI for non-culprit lesions in STEMI

Two specific situations where simultaneous multivessel angioplasty maybe justified during STEMI are presented.

#### TCTAP C-030

**Rescue from Left Main Coronary Artery Bifurcation Spiral Dissection During Emergent PCI Procedure**

Hsu-Ping Wu<sup>1</sup>

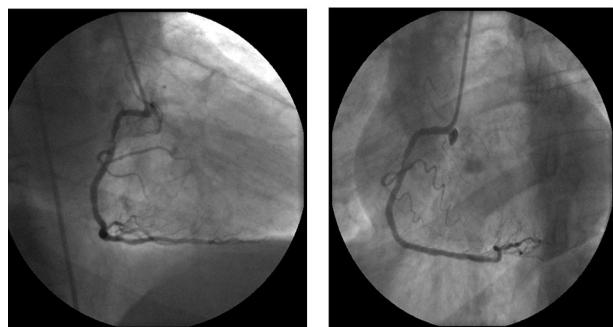
<sup>1</sup>Cardiovascular Medicine, Mackay Memorial Hospital, Hsinchu, Taiwan

#### [CLINICAL INFORMATION]

**Patient initials or identifier number.** JCC

**Relevant clinical history and physical exam.** 38 year-old lady presented acute chest pain followed by persisted chest tightness in the evening. Clinically NSTEMI was diagnosed as elevated cardiac enzymes but no obvious ST-T elevation. However, it transformed into STEMI the next morning.

Thrombus containing lesions in RCA



RAO

LAO

